DATE: _____

CLINICAL AREA: _____

How' YOU Doin'??

Patient Assessment

November 2002

Instructions:

- ❑ Test your staff's knowledge by asking at least 6 of them the following questions.
- ❑ Indicate in the boxes whether each **answered the question correctly (Y)** or **were not able to answer the question (N).** Use the attached answer sheet to provide "just-in-time" teaching.
- ❑ Give everyone a pat on the back for a job well done!!! Then, **send the results to Ginnie Daine (7D37) by _____.**
- ❑ Got questions on a particular topic?? Check the box to the left of the topic and we'll be in touch! ☺

	? Critical Issue	1	2	3	4	5	6
	1. How would you determine if the H&PE is valid?						
	2. Select any medical record and show me evidence of the patient's advance directive status. For example, if the patient has an AD, is it in the medical record? If not, is there evidence that someone is trying to obtain a copy?						
	3. Please locate the Communicable Disease History in the Interdisciplinary Notes.						
	4. If your patient reports they have a history of Vancomycin Resistant Enterococcus (VRE), what steps will you take?						
	5. Please locate the Functional Risk Screening assessment in the medical record.						
	6. Describe how you communicate positive findings on the Functional Risk Screening.						
	7. Under what circumstances would you reassess your patient's Functional Risk?						
	8. When would you expect the dietitian/designee to follow-up on the results of the Nutrition Risk Screening?						
	9. Describe how your patient would receive information about drug-nutrient interactions.						
	10. Please list the criteria used to assess the patient's teaching/learning needs.						
	11. Please locate the Teaching/Learning assessment in the medical record.						
	12. Please locate evidence of patient/family teaching in the medical record.						
	13. Discuss how you provide medication teaching to your patient/family.						
	14. How do you measure the outcomes of your patient teaching?						
	15. How soon after the patient is admitted should the nursing assessment be completed?						
	16. What are the CC's criteria for assessment of potential child abuse or vulnerable adult abuse or neglect?						

How' YOU Doin'??

The Answer Sheet☺

Patient Assessment

November 2002

Critical Issue
1. How would you determine if the H&PE is valid? • A junior or senior physician member of the medical staff dictates or handwrites in the progress notes the patient's H&PE within 24 hours after admission. • If the H&PE is handwritten, it must be dated on the calendar day of admission, or it must be dated *AND TIMED* if it is written on the calendar day after admission. Dating and timing is necessary to confirm that the report was actually entered within 24 hours of inpatient admission. • Take a look at the Medical Record Handbook (2000) for additional information on this topic. Medical Records staff wanted you to know that an updated Medical Record Handbook will be made available in 2003.
2. Select any medical record and show me evidence of the patient's advance directive status. For example, if the patient has an AD, is it in the medical record? If not, is there evidence that someone is trying to obtain a copy? • If patient has a copy of the AD with them, nurse will copy and file in the Advance Directive section of the Medical Record • If patient has an AD but it is not with them, nurse will assist the patient to obtain a copy. Until the AD has been received from the patient, it should be communicated to each assigned nurse the status of the AD. It is documented in the medical record at least daily what steps are being taken to obtain the AD until the AD has been filed in the medical record. As an alternative, the nurse may encourage the patient to execute an NIH Advanced Directive. • If patient does not have an AD at all, nurse will encourage the patient to execute an AD by using Advance Directive for Health Care and Medical Research Participation (NIH Form 200). • You can locate the CC policy, "Advance Directive," by clicking on http://push.cc.nih.gov/policies/PDF/M92-7.pdf.
3. Please locate the Communicable Disease History in the Interdisciplinary Notes. Would be recorded by RN or LPN within the first 8 hours of admission to the CC. Prints on the IDN on the day of admission.
4. If your patient reports they have a history of Vancomycin Resistant Enterococcus (VRE), what steps will you take? • Notify HES and the physician/designee to determine status of VRE. • Medical order would be entered into MIS designating the appropriate isolation precautions . . . Contact Isolation in this case. • Each PCU should have the CC Isolation Guidelines posted on their unit. If you need the CC Isolation Guidelines, please contact Hospital Epidemiology Services (6-2209) to obtain a copy.
5. Please locate the Functional Risk Screening assessment in the medical record. Would be recorded by RN or LPN within the first 8 hours of admission to the CC. Prints on the IDN on the day of admission.
6. Describe how you communicate positive findings on the Functional Risk Screening to the physician/designee. The method of communicating assessment data to the interdisciplinary team is determined by the team. Members of the team should be able to describe this process and what they do with this information. For example, enter a medical order for Rehabilitation Medicine consultation. Or, if not warranted, document

in the progress notes that the assessment has been reviewed and the following action taken or not taken.

7. Under what circumstances would you reassess your patient's Functional Risk?

   Any change in the patient's condition that would likely impact on their ability to communicate, move, or work.

8. When would you expect the dietitian/designee to follow-up on the results of the Nutrition Risk Screening?

   The Nutrition Risk Screening Assessment will be recorded by an RN or LPN within the first 8 hours of admission to the CC. The information prints on the admission IDN and it prints in the dietitians' office. The dietitian/designee will follow-up on the results of the assessment within 48 hours of inpatient admission. RNs or LPNs who identify outpatients who may be at nutritional risk should notify the dietitian by phone or page.

9. Describe how your patient would receive information about drug-nutrient interactions.
   - The Health Tech from Nutrition Department provides inpatients with handout and 1:1 patient education. The RN provides this information to the outpatient who is receiving a drug while in the clinic or day hospital. The Outpatient Pharmacist is responsible for drug-nutrient counseling for take-home medications.
   - Nursing reinforces this information.
   - Drug-Nutrient patient information can be obtained from http://www.cc.nih.gov/ccc/patient_education/drug_nutrient/

10. Please list the criteria used to assess the patient's teaching/learning needs.

    Assessment of the pt/family's learning abilities, preferences, and readiness to learn is done on admission and when there is a significant change in the patient's condition. This assessment includes:
    - cultural and religious practices
    - emotional barriers (stress, new diagnosis)
    - desire and motivate to learn (attitude, non-compliance)
    - physical (pain, hearing/vision problems, sleep deprivation, sedation, nausea)
    - cognitive limitations
    - language barriers (aphasia, non-English speaking)
    - preferred method of learning (reading, video, role play, play, discussion, demonstration)
    - financial implications of care choices

11. Please locate the Teaching/Learning assessment in the medical record.

    Located in the IDN on the day of admission.

12. Please locate evidence of patient/family teaching in the medical record.

    In the MIS, select patient's name → Retrieval Guide → Interdisciplinary Notes → Patient Education (all) These steps should retrieve all information recorded under "Teaching/Learning" in any of the 13 categories as well as an teaching documented by other disciplines who use MIS (Nutrition, Social Work, and Spiritual Ministries).

13. Discuss how you provide medication teaching to your patient/family.

    RNs and others should be able to describe the interdisciplinary approach in your patient care area. Description of the process should include some of these elements:
    - Physician's role when a new drug is prescribed
    - RN's role in reviewing rationale, name, dose, route, schedule, administration instructions, and side effects to report
    - Dietitian's role in educating about drug-nutrient interactions
    - Pharmacist's role in education at time of discharge
    - How audiovisual forums are used to facilitate variety of learning styles and educational levels

14. How do you measure the outcomes of your patient teaching?

RNs and others should be able to describe how they validate that patient/family has acquired the necessary knowledge and skills to carry out prescribed care and/or medications. Description of this process might include:

- Verbalizes understanding
- Return demonstration
- Observation of relevant behaviors
- Pen/paper testing

Staff may also want to consider any aggregate Performance Improvement data they have collected that supports how successful their teaching interventions have been. For example, the VAD Service and HES collect data on VAD infection rates . . . analysis of these data may indicate if our teaching strategies r/t VAD care have been successful. Think about the aggregate date you use in your patient care area.

15. How soon after the patient is admitted should the nursing assessment be completed?

Within 8 hours.

16. What are the CC's criteria for assessment of potential child or vulnerable adult abuse or neglect;

Physical Appearance

- Unexplained multiple bruises, burns, fractures, lacerations, or abrasions
- Consistent hunger, poor hygiene, inappropriate dress, constant fatigue, listlessness
- Unattended physical problems or medical needs

Behavioral

- Appears overly fearful or reluctant to respond when questioned
- Pt/family provide conflicting accounts of the incident
- Family seeks to prevent the patient from interacting privately or speaking openly with healthcare providers

Sexual Abuse

- Difficulty in walking or standing
- Torn, stained, or blood underclothing
- Pain or itching of genital area
- Trauma to genital or perineal area

For additional information, review the 2 CC's policies:

- MEC Policy 94-5 Reporting Child Abuse/Neglect in the CC (http://push.cc.nih.gov/policies/PDF/M94-5.pdf)
- MEC Policy 97-5 Policy on Reporting Vulnerable Adult Abuse, Neglect, Self-Neglect, or Exploitation (http://push.cc.nih.gov/policies/PDF/M97-5.pdf)